REPORT OF RECOMMENDATIONS AND FINDINGS ON THE PROPOSAL TO LICENSE RADIOLOGIC PRACTITIONER ASSISTANTS

By the Nebraska
State Board of Health

To the Director of the Division of Public Health of the Department of Health and Human Services, and the Members of the Health and Human Services Committee of the Legislature

September 22, 2014

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Part One: Preliminary Information

Introduction

The Credentialing Review Program is a review process advisory to the Legislature which is designed to assess the need for state regulation of health professionals. The credentialing review statute requires that review bodies assess the need for credentialing proposals by examining whether such proposals are in the public interest.

The law directs those health occupations and professions seeking credentialing or a change in scope of practice to submit an application for review to the Department of Health and Human Services, Division of Public Health. The Director of this Division will then appoint an appropriate technical review committee to review the application and make recommendations regarding whether or not the application in question should be approved. These recommendations are made in accordance with statutory criteria contained in Section 71-6221 of the Nebraska Revised Statutes. These criteria focus the attention of committee members on the public health, safety, and welfare.

The recommendations of technical review committees take the form of written reports that are submitted to the State Board of Health and the Director of the Division along with any other materials requested by these review bodies. These two review bodies formulate their own independent written reports on the same credentialing proposals. All reports that are generated by the program are submitted to the Legislature to assist state senators in their review of proposed legislation pertinent to the credentialing of health care professions.

The Members of the Nebraska State Board of Health

Kevin Borcher, PharmD, RP

Janet Coleman (public member)

Shane Fleming, BSN, MSN, RN

Russell Hopp, D.O.

Diane Jackson, APRN

Dale Michels, MD (Chair)

Anthony Moravec, DVM

Debra Parsow (public member)

Roger Reamer, MBA (Hospital Administrator)

Rich Robinson, PE

Paul Salansky, OD (Board Secretary)

Wayne Stuberg, PhD, PT

Travis Teetor, MD

Joshua Vest, DPM

Jeromy Warner, PsyD, LP

Daryl Wills, DC (Vice Chair)

Meetings Held

The Meeting of the Credentialing Review Committee of the Board, Held August 11, 2014

The Meeting of the Full Board of Health, Held September 22, 2014

Part Two: Summary of Recommendations on the Radiologic Practitioner Assistants' Proposal

Summary of the Technical Committee Recommendations

The committee members recommended approval of the Radiologic Practitioner Assistants' proposal.

The committee members approved the following ancillary recommendation:

> The committee members recommended that licensure for RAs be administered by the Board of Medicine and Surgery if the proposal were to pass the Legislature.

Summary of the Recommendations of the Nebraska State Board of Health

- The advice of the Board's Credentialing Review Committee to the full Board

  The Board Credentialing Review Committee Members took action to advise the full Board of Health on whether or not to recommend approval of the RPA proposal.

  Voting to advise approval of the proposal were Moravec, Fleming, and Parsow. There were no nay votes or abstentions.

- The recommendations of the full Board of Health

  The Board members voted unanimously to approve the recommendations of their Credentialing Review Committee which had been to recommend approval of the applicants' proposal.

Part Three: Summary of the Radiologic Practitioner Assistants' Proposal

The proposal seeks to credential a new category of radiologic technology practitioner in Nebraska. This category of provider is identified by several different titles: 1) Radiology Practitioner Assistant (RPA); 2) Radiology Assistant (RA); and 3) Registered Radiologist Assistant (RRA).

The applicants seek to create a single, common license for all members of these three professional categories, regardless of any differences in education and training among them. The following briefly describes the differences:

> A practitioner must undergo an additional year of education and training beyond that received by radiologic technologists in order to become an RRA. Becoming an RPA requires an additional two years of education and training including 1800 additional clinical clock hours under a radiologist. The RA category is the highest tier of the profession, receiving as much as five additional years of education and training beyond that received by radiologic technologists.

Applicant group representatives and the members of the technical review committee agreed that licensure of RAs would be administered by a Radiologic Technology Committee of the Board of Medicine and Surgery to include two RAs and one physician member who would be a Radiologist if the proposal were to be enacted by the Legislature.

Radiology Practitioner Assistants, or Radiologist Assistants (CBRPA), or Registered Radiologist Assistants (ARRT) are experienced Radiologic Technologists with at least an additional 2 years of advanced training, and are board certified as either RPAs/RAs (CBRPA), or as RRAs (ARRT).

As part of their licensed scope of practice RPAs/RAs would be allowed to provide a detailed patient history, examine the patient, take radiologic images, as ordered by a physician. They would also be allowed to perform fluoroscopy and report initial findings to a radiologist for them to interpret.

The following amendments were approved by the committee members:

Amendment One: Pertinent to initial licensure, continuing education, licensure renewal, and statutory authority issues. This amendment began by stating that:

> Pertinent to items #4 on pages 9 and 10, #s 17 and 18 on page 13 and 14, and #5 on page 17 of the Application, the applicants stated that, "The Nebraska Department of Health and Human Services will determine the standards for education and continuing education for the Radiologist Assistant. Any reference to a private organization is for example only."

This amendment stated that Radiologist Assistants (RAs) would be required to complete at least 24 hours of continuing education every two years. It also defined the requirements that courses must satisfy to be accepted as continuing education for this profession.

Amendment Two: Pertinent to scope of practice issues, this amendment stated that:

The following amendment replaces the paragraph that includes eleven bullet points on the job duties of a Radiologist Assistant in the ***Radiologist Practitioner/Radiologist Assistant New Credential Application Booklet*** *on page 6, dated Fall, 2013*

There are three levels of supervision based on the Centers for Medicare and Medicaid Services (CMS) definitions[4]

1. In addition to medical radiographer tasks, a radiologist assistant may perform advanced diagnostic imaging procedures, including fluoroscopy, under the direction of a radiologist. Those procedures include, but are not limited to:
   (a) Enteral and parenteral procedures;
   (b) Injecting diagnostic agents to sites other than intravenous;
   (c) Diagnostic aspirations and localizations.
2. A Radiologist Assistant may perform the following Pre-imaging procedures:
   (a) Review of medical records to verify patient and procedure; obtain medical history and perform physical examination, evaluate medical record, history and physical examination for contraindications for the procedure (e.g., compliance with preparation instructions for the procedure, pregnancy, medications), discrepancies and/or contraindications must be reviewed with the supervising physician;
   (b) Discuss examination/procedure details (including risks, benefits and follow-up instructions) with patient or patient representative;
   (c) Obtain informed consent (patient must be able to communicate with the radiologist for questions or further information as needed);
   (d) Apply electrocardiography (ECG) leads and recognize life threatening abnormalities when necessary;
   (e) Routine urinary catheterization;
   (f) Venipuncture;
   (g) Administer oxygen as prescribed; and
   (h) Position patients to perform required procedures.
3. A Radiologist Assistant may perform Imaging Review**:**
   (a) Evaluate images for completeness and diagnostic quality;
   (b) Recommend additional images in the same modality as required (general radiography, CT, MRI);
   (c) Evaluate images for diagnostic utility and report clinical observations to the radiologist;
   (d) Review imaging procedures, make initial observations and communicate observations to the radiologist; and

4i. A Radiologist Assistant may perform Post-processing procedures:
   (a) Routine CT (e.g., 3D reconstruction, modifications to field of vision (FOV), slice spacing, algorithm);
   (b) Specialized CT (e.g., cardiac scoring, shunt graft measurements); and
   (c) MR date analysis (e.g., 3D reconstruction, maximum intensity projection (MIP), 3D surface rendering, volume rendering).

4ii. A Radiologist Assistant may perform Post-Radiologic procedures:
   (a) Record previously communicated initial observations of imaging procedures according to pre-approved protocols;
   (b) Communicate radiologist report to the referring physician;
   (c) Provide radiologist-prescribed post care instructions to patients;
   (d) Perform follow-up patient evaluation and communicate findings to the radiologist;
   (e) Document procedure in appropriate record and document exceptions from established protocol or procedure; and
   (f) Write patient discharge summary for review and co-signature by the radiologist

4iii. A Radiologist Assistant may perform Quality Control procedures:
   (a) Participate in quality improvement activities within the medical practice (e.g.,quality of care, patient flow, reject-repeat analysis, patient satisfaction); and
   (b) Assist with data collection and review for clinical trials or other research.

GENERAL SUPERVISION[1]

1. A Radiologist Assistant may perform under general supervision the following:
   (a) Administer contrast agents and/or radiopharmaceuticals as prescribed by the radiologist;
   (b) Monitor intravenous flow rate; and
   (c) Provide information to patients on the effects and potential side effects of the pharmaceutical required for the examination; and
   (d) Monitor patients for side effects or complications and report findings to the radiologist as appropriate.
   (e) Parenteral medication administration procedures, excluding imaging agents.
   (f) Administer general medications as related to the procedure and prescribed by the radiologist.
2. A Radiologist Assistant may perform the following imaging procedures and the use of contrast agents and medicines as prescribed by the radiologist:
   (a) Upper GI studies;
   (b) Esophagus studies;
   (c) Small bowel studies;
   (d) Barium enema studies;
   (e) Cystogram;
   (f) T-tube cholangiogram;
   (g) Hysterosalpingogram
   (h) Nasoenteric and oroenteric feding tube placement;
   (i) Fistulagram/sinogram
   (j) Swallowing study
   (k) Contrast media administration and catheter placement

DIRECT SUPERVISION[2]

1. A Radiologist Assistant may perform the following Imaging procedures that requires direct supervision and the use of contrast agents:
   (a) Lumbar puncture using fluoroscopic guidance;
   (b) Thoracentesis and paracentesis with appropriate image guidance;
   (c) Lumbar, thoracic, and cervical myelogram;
   (d) Ductogram (galactogram);
   (e) Lower and upper extremity venography;
   (f) Retrograde urethrogram
   (g) Port injection

(h) Loopogram;
(i) Sialogram;
(j) Arthrogram (conventional, computed tomography (CT), magnetic resonance imaging (MRI), Ultrasound (US);
(k) Joint injection and aspiration
(l) Peripherally inserted central catheter (PICC) placement

2. A Radiologist Assistant at the direction of a radiologist , may administer imaging agents and prescribed medications as related to the procedure.
3. A Radiologist Assistant may not prescribe medications.
4. Oral medications, excluding imaging agents, always require direct supervision.

PERSONAL SUPERVISION[3]

1. A Radiologist Assistant may assist the radiologist with other invasive procedures.
2. Parenteral medication administration procedures, excluding imaging agents.
3. Provide information to patients on the effects and potential side effects of the pharmaceutical required for the examination.

OBSERVATIONS

1. Initial findings and observations made by a Radiologist Assistant may be communicated solely to the radiologist and do not constitute diagnoses or interpretations.

2. A radiologist will supervise no more than two Radiologist Assistants (RA).

2010 NEBRASKA MEDICAL RADIOGRAPHY PRACTICE ACT

38-1904. Interpretative fluoroscopic procedures, defined.
Interpretative fluoroscopic procedures means the use of radiation in continuous mode to provide information, data, and film or hardcopy images for diagnostic review and interpretation by a licensed practitioner as the images are being produced.

38-1905. Licensed practitioner, defined. Licensed practitioner means a person licensed to practice medicine, dentistry, podiatry, chiropractic, osteopathic medicine and surgery, or as an osteopathic physician.

[1] GENERAL supervision: A service furnished under the overall direction and control of the supervising physician, but his or her physical presence is not required during the performance of the procedure.
[2] DIRECT supervision: The physician is immediately available or physically present, interruptible and able to furnish assistance and direction through the performance of the procedure; the physician does not have to be present in the same room when the procedure is being performed or within any particular hospital boundary, such as the confines of the hospital campus.
[3] PERSONAL supervision: The physician is present in the room when the service is being performed.
[4] There are three levels of supervision based on CMS definitions: the supervising physician does not necessarily need to be of the same specialty as the procedure or service that is being performed or from the same department as the ordering physician. However, the supervising physician or non-physician practitioner must have within his or her state scope of practice and hospital-granted privileges, the ability to perform the service or procedure.
5.ALL supervision is done by a radiologist.

The text of this proposal and these two amendments can also be found under the RPA topic area of the credentialing review program link at http://dhhs.ne.gov/Pages/reg_admcr.aspx

Part Four: Discussion on the Issues

Comments by Kenneth Kester, PharmD, JD, Chairperson of the Radiologic Practitioner Assistant's Technical Review Committee, at the August 11, 2014 Special Meeting of the Board's Credentialing Review Committee

Dr. Kester provided an overview of the work of the technical review committee. He stated that the committee thoroughly reviewed the issues and thoughtfully studied the information provided to them by the contending parties. He went on to express confidence in the recommendations made by the committee on the issues, adding that the committee members diligently focused their questions on the implications of the proposal for public health.

Dr. Kester commented that some of the information provided by the interested parties was anecdotal information, and that it would have been helpful to the committee members to have been provided with more data pertinent to the issues from states that have already licensed RAs. Such data would have been helpful to the committee members in their effort to assess the safety implications of the proposal, as well as assess the ability of the proposal to improve access to care, for example.

Pertinent to access to care issues Dr. Kester stated that it is difficult to foresee the extent to which the proposal would improve access to radiologic services. He went on to state that, initially, only three persons would be licensed if the proposal were to pass. He acknowledged that passing licensure would make Nebraska a more attractive place for RAs to work. However, there is no way of knowing how many RAs from other states this might bring in to our state. He added that a quick survey of neighboring states that have RA licensure is not encouraging, making the observation that of all the states contiguous to Nebraska only Colorado has more than ten licensed RAs, for example.

Pertinent to education and training issues Dr. Kester stated that he is comfortable with the amount of training RAs would receive under the terms of the proposal, and that as long as they work in conjunction with radiologists at all times, safety concerns should be manageable.

Mr. Fleming asked Dr. Kester what background a person must have to qualify as an RA. Dr. Kester responded that an RA must first be educated and trained as a Radiologic Technologist. He went on to state that some RAs have as much as five years of additional training beyond the RT credential, whereas some have two years of additional training. However, the proposal calls for one common license for all RAs.

Mr. Fleming asked Dr. Kester whether RAs must always work under the orders of a radiologist. Dr. Kester responded in the affirmative.

Comments by Carter Mayotte, RA, on behalf of the applicant group

Mr. Mayotte informed the committee members that the RA profession was created during the 1990's by the military in response to a decline in the number of radiologists available to provide radiologic services. RAs were created to help fill this gap in services, but were to practice under the supervision of radiologists, functioning as radiology extenders. Mr. Mayotte commented that there are approximately five-hundred RAs, nationally, providing outreach services under indirect physician supervision. He added that the ability of RAs to provide outreach services under indirect supervision enables RAs to have a significant positive impact on access to services in medically underserved areas.

Ms. Parsow asked Mr. Mayotte whether or not the public needs this proposal, or whether it is a matter of making radiologic services more convenient. Mr. Mayotte argued that the proposal is necessary for full access to radiologic services in Nebraska. Ms. Parsow asked Mr. Mayotte what is the worst case scenario if the proposal does not pass? Mr. Mayotte responded that the most qualified extenders would continue not being allowed to provide the services in question, while other providers such as PAs, for example, would continue to be the providers doing most of this work. Ms. Parsow commented that there is nothing in the proposal that would prevent PAs from doing this work even if the proposal were to pass.

Mr. Fleming made the observation that there are indications of a decline in the availability of fluoroscopy equipment in rural hospitals in Nebraska, and asked Mr. Mayotte if the proposal would be able to impact on this situation. Mr. Mayotte responded that licensing RAs to provide outreach services in rural areas might persuade at least some rural hospitals to keep their fluoroscopy units.

Comments by Sarah Dunbar on behalf of the Nebraska Radiologic Society

Ms. Dunbar informed the committee members that members of the Nebraska Radiological Society expressed concerns about the invasiveness of some aspects of the proposed RA scope of practice during the technical committee's review on these issues, arguing that RA education and training is not sufficient for them to provide such invasive procedures as fluoroscopy without a supervising radiologist being present. Ms. Dunbar went on to say that there is a significant gap between radiologists and RAs in hours of clinical training. Radiologists have approximately ten thousand clinical hours compared to approximately two thousand clinical hours for RAs, for example. She added that radiologists also have greater diagnostic skills than do RAs.

Carter Mayotte responded to these comments by stating that it is not the intention of RAs to replace radiologists, adding that RAs would continue to work closely with radiologists under the terms of the proposal, if it were to pass. He added that RAs are trained by radiologists to work with radiologists, and are trained to do everything they can to provide radiologists with the information they need to make a diagnosis. He clarified that RAs do not diagnose. They function only as physician extenders.

Mr. Fleming asked Mr. Mayotte whether RAs would be able to order medications without consulting with a physician. Mr. Mayotte responded that RAs always consult with a physician before ordering a medication for a patient.

Discussion by the Board's Credentialing Review Committee Members

Dr. Moravec commented that telemedicine is a technology that could address concerns raised by the radiologists. Effective use of this technology could, in effect, provide the equivalent of physician participation in a diagnostic procedure even though the physician might be many miles away.

Dr. Kester commented that the lack of hard data pertinent to such things as the extent of the need for increased access, the ability of RAs to satisfy this need, and the extent of new risk from the proposal itself continues to hamper efforts to evaluate the potential impact of the proposal if it were to pass. Dr. Kester commented that one of the on-going uncertainties pertains to the number of potential licensees if the proposal were to pass. He questioned whether licensing three RAs would make a significant impact on access to radiologic services in Nebraska.

Mr. Mayotte responded to Dr. Kester's comments by stating that the current number of potential licensees should not be a concern because licensure will make Nebraska a more attractive place for RAs to work, and that some RAs from other states will eventually come to Nebraska to provide their services. He added that he knows that similar proposals for RA licensure have played a role in bringing more RAs to practice in other states that have passed such proposals.

Part Five: Recommendations of the Board of Health

Actions Taken by the Board Members:

The members of the full Board of Health took action on the recommendation of their Credentialing Review Committee during their September 22, 2014 bimonthly meeting. The committee recommendation was to approve the applicants' proposal. The Board members took the following action on this committee recommendation:

Voting to approve this recommendation were Borcher, Fleming, Salansky, Stuberg, Vest, Wills, Moravec, Hopp, Jackson, Michels, Parsow Reamer, Robinson, Teetor, and Warner. There were no nay votes or abstentions. By this action the members of the full Board of Health recommended approval of the recommendation of their Credentialing Review Committee, thereby recommending approval of the applicants' proposal.